SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
Filing Company:	*United National Life Insurance Company of America*	*State Tracking Number:*	*41860*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: UAPPH4-08	SERFF Tr Num: GRTT-126079754	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 41860
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Ann Ryan	Disposition Date: 03/19/2009
	Date Submitted: 03/18/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Hospital Indemnity Application	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed in IL, our state of domicile, on March 18, 2009
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/19/2009	Explanation for Other Group Market Type:
	State Status Changed: 03/19/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

We are submitting the above referenced application for your review and approval.

It is new and will be used with the following forms which were previously approved by your Department:

Form Number Type of Coverage

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
Filing Company:	*United National Life Insurance Company of America*	*State Tracking Number:*	*41860*
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TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
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U9910-AR Hospital Confinement Indemnity
U9911-AR Hospital Confinement Indemnity & Home Care Indemnity
U0430-AR First Diagnosis Cancer

The application will be used by licensed agents appointed by our company to sell our approved products.

This application has been printed by our computer and laser printer. We reserve the right to change the font (typeset) when and if a new font becomes available. Any variable information is bracketed.

Your consideration and approval of this filing would be appreciated.

Company and Contact

Filing Contact Information

Ann Ryan,	aryan@gtlic.com	
1275 Milwaukee Ave.	(847) 904-5587 [Phone]	
Glenview, IL 60025	(847) 699-0093[FAX]	
Filing Company Information		
United National Life Insurance Company of America	CoCode: 92703	State of Domicile: Illinois
1275 Milwaukee Ave.	Group Code: 903	Company Type:
Glenview, IL 60025	Group Name:	State ID Number:
(847) 803-5252 ext. [Phone]	FEIN Number: 37-1095206	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	IL, our state of domicle fee, is $50 per form Arkansas fee is $20 per separate form

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Therefore, fee is $50

Per Company: No

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	$50.00	03/18/2009	26506104

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/19/2009	03/19/2009

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

Disposition

Disposition Date: 03/19/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

Form Schedule

Lead Form Number: UAPPH4-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UAPPH4-08-AR	Application/ Enrollment Form	Application	Initial		51	UAPPH4-08-AR.pdf

United National Life Insurance Company of America - PO Box 1154 - Glenview - Illinois - 60025-1154 - 800-207-8050
Combined Application for Hospital Confinement (U9910) / Hospital Confinement & Home Care Indemnity (U9911)
First Diagnosis Cancer (U0430)

Section A: Applicant Information

Applying For: (*please check one)* ☐ New Coverage ☐ Reinstatement ☐ Increase in Benefits

Primary Applicant

1. Last Name _____ First Name _____ MI _____

Social Sec #____-____-____ Sex _____ Age _____ Birth date ____/____/___ Height ____/_____ Weight _____

Spouse

2. Last Name _____ First Name _____ MI _____

Social Sec #____-____-____ Sex _____ Age _____ Birth date ____/____/___ Height ____/____ Weight _____

Dependents

3. Last Name _____ First _____ MI __ Sex __ Age ___ Birth date ___/___/___ SSN_____-____-_____

4. Last Name _____ First _____ MI __ Sex __ Age ___ Birth date ___/___/___ SSN_____-____-_____

5. Last Name _____ First _____ MI __ Sex __ Age ___ Birth date ___/___/___ SSN_____-____-_____

6. Last Name _____ First _____ MI __ Sex __ Age ___ Birth date ___/___/___ SSN_____-____-_____
(For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.)

7. Street Address _____ City _____ ST ____ Zip Code _____

8. Telephone (Day) _____ Applicant's E-mail Address_____

Section B: Coverage Selection and Premiums

[Hospital Confinement Indemnity (U9910)	Hospital Confinement & Home Care Indemnity (U9911) **Benefits Plus**	First Diagnosis Cancer (U0430) **Cancer Plus**
Coverage: (*check applicable)* ☐ Primary Applicant ☐ Spouse ☐ Dependent Children	**Coverage: (*check applicable)*** ☐ Primary Applicant ☐ Spouse ☐ Dependent Children	**Coverage: (*check applicable)*** ☐ Primary Applicant ☐ Family
Plan: *(check one)* ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E	**Plan:** *(check one)* ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G	**Scheduled Base Plan** (*check one*) ☐ Option A ☐ Option B ☐ Option C ☐ Option D
		Riders ☐ Heart Attack and Stroke ☐ Return of Premium ☐ Lump Sum $_____ $1,000 - $10,000
Modal Premium: $ _____	Modal Premium: **$** _____	Modal Premium: **$** _____

Premium Payment Modes: ☐ Monthly Bank Draft (0.84) ☐ Quarterly (.265) ☐ Semi-Annual (.52) ☐ Annual
(If applying for Benefits Plus and Cancer Plus, only one Policy Fee is required)
Total Premium Collected: $_____]

Section C: Medical/Underwriting Questions

Replacement question must be answered for ALL plans.

1a. Will the coverage(s) being applied for replace any existing hospital, medical, ,major medical, or hospital confinement Indemnity insurance in this or any other company? ……..... ☐Yes ☐ No
If yes, name of person this applies to _____ Company _____
If yes, submit appropriate replacement form – (if needed in your state).

Hospital Confinement Indemnity (U9910)

Answer the following question if applying for the Hospital Confinement Indemnity (U9910)

1b. Does any person to be insured have any inforce or applied for hospital confinement indemnity insurance in this or any other company? …… ☐Yes ☐ No
If yes, name of person this applies to _____Amount of Coverage _____

Benefits Plus - Hospital Confinement & Home Care Indemnity (U9911)

Answer the following questions if applying for the Benefits Plus Plan (U9911)

If the answer to any of the following questions is "Yes", that person does not qualify for this plan.

1c. Is any person to be insured currently in a hospital, nursing home or receiving home health care, or is disabled, receiving disability or is applying for disability benefits or will do so in the next 60 days? ……..... ☐Yes ☐ No

2c. In the past 24 months, has any person to be insured been diagnosed by a member of the medical profession as having a heart attack or stroke or had heart surgery/ bypass or angioplasty? ……..…. ☐Yes ☐ No

3c. In the past 24 months has any person to be insured been diagnosed or received treatment by a member of the medical profession for chronic obstructive lung disease, insulin dependent diabetes, drug or alcohol use, cancer (not skin cancer), congestive heart failure, or chronic liver or kidney disease? …… ☐Yes ☐ No

4c. In the past 12 months, has any person to be insured been advised by a member of the medical profession to have surgery but has not yet done so? ……..…. ☐Yes ☐ No

5c. Has any person to be insured been treated or been diagnosed by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC), or HIV infection?……..…. ☐Yes ☐ No

If yes, name of person this applies to _____

Cancer Plus - First Diagnosis Cancer (U0430)

Answer the following questions if applying for the Cancer Plus (U0430):

1d. In the past 10 years, has any person to be insured had, ever diagnosed as having, received medication for, or been treated by a medical practitioner for:
   i. Leukemia, Hodgkin's disease, malignant melanoma, sarcoma or any internal cancer, or had radiation or chemotherapy for these conditions? ..... ☐Yes ☐ No
   ii. Heart attack, heart bypass, angioplasty or stent placement, angina, stroke or Transient Ischemic Attack (TIA)? ..... ☐Yes ☐ No

2d. In the past 12 months, has any person to be insured been advised by a member of the medical profession to have surgery but has (have) not yet done so? ……..…… ☐Yes ☐ No

3d. In the past 24 months, has any person to be insured experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner, or to have or schedule a diagnostic test for any of the conditions listed in question 1di and 1dii? ..... ☐Yes ☐ No

4d. For any person to be insured, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead, suffer from cancer, diabetes or heart disease before the age of 60? … ..... ☐Yes ☐ No

5d. In the past 12 months has any person to be insured used any tobacco products? ..... ☐Yes ☐ No

If yes, name of person this applies to _____

If question 1di, 2d, 3d or 4d is answered "YES" that person does not qualify for the Cancer Plus Plan.
If question 1dii is answered "YES" that person does not qualify for the Heart Attack or Stroke Rider.

Section D: Authorization / Agreement

IN SOME STATES WE ARE REQUIRED TO ADVISE YOU OF THE FOLLOWING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false, incomplete, or deceptive statement of a material fact may be guilty of insurance fraud.

I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction, such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the MIB, Inc.. This Authorization includes all information about drugs, alcoholism, and mental illness. I authorize all sources, except the MIB, Inc. to give such records to any agency employed by United National Life Insurance Company of America to collect such information. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it. I have read or had read this authorization and I have also received a copy or will be provided a copy of the "Notice to Applicant, Parts 1 and 2" and the Description of Information Practices form prepared by United National Life Insurance Company of America (if required in your state).

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that omissions, misrepresentations or misstatements could result in denial of an otherwise valid claim and/or rescission, voiding or reformation of insurance. I understand that no insurance will be effective until the effective date stated in my policy and until all eligibility requirements are met.

_____ _____ _____ _____

SIGNATURE OF APPLICANT DATE SIGNATURE OF APPLICANT'S SPOUSE (if applicable) DATE

I certify that I have asked all the questions, and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for: □ is or is likely, □ is not or is not likely to replace or change any existing policy(ies) or contract(s).

X _____

Soliciting Agent ***Print Agent Name*** ***Agent's Code***

X _____

Date Signed ***City, State*** ***Agent E-Mail Address***

Mail policy to: □ Agent □ Policyholder

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to honor withdrawals to be drawn by United National Life Insurance Company of America.

TO

_____

Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of United National Life Insurance Company of America, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Bank Routing #: _____ Account #:_____

Account Type: □ Savings Account *(attach a voided "sample" check) if applicable, or a deposit slip* □ Checking Account *(attach a voided sample" check)*

I agree that my rights in respect to each payment shall be the same is if it were drawn by me and signed personally by me.

This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

_____ _____

Printed name of insured if different from premium payer Premium payer's signature, as it appears on bank records

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Product Name:	*UAPPH4-08*		
Project Name/Number:	*Individual Hospital Indemnity Application/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GRTT-126079754*	*State:*	*Arkansas*
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Supporting Document Schedules

Satisfied -Name: Flesch Certification — **Review Status:** Approved-Closed — 03/19/2009

Comments:
Readability Certification
Arkansas Certificate of Compliance

Attachments:
Readcert for UAPPH4-08-AR.pdf
AR Cert of Compliance (UAPPH4-08-AR).pdf

Bypassed -Name: Application — **Review Status:** Approved-Closed — 03/19/2009

Bypass Reason: See Form Schedule. We are filing a new application.

Comments:

Bypassed -Name: Outline of Coverage — **Review Status:** Approved-Closed — 03/19/2009

Bypass Reason: Not applicable.

Comments:

Satisfied -Name: Statement of Variability — **Review Status:** Approved-Closed — 03/19/2009

Comments:
Arkansas Statement of Variability

Attachment:
AR STATEMENT OF VARIABILITY.pdf

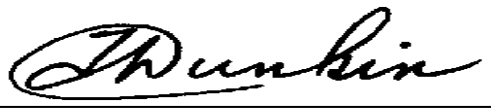
CERTIFICATE OF READABILITY

Form Number(s): UAPPH4-08-AR

Flesch Test Score(s): 50.75

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



Thomas Dunkin, President

Date: March 17, 2009

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Re: Policy Form UAPPH4-08-AR

The United National Insurance Company of America, Glenview, Illinois does hereby certify that this policy form submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements for this category of insurance pursuant to the Arkansas Department of Insurance.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

Thomas Dunkin
President

Date 3/18/09

United National Life Insurance Company of America

STATEMENT OF VARIABILITY
For
UAPPH4-08-AR (Application)

The bracketing of variable text in Application form UAPPH4-08-AR is limited to the following:

Section A
Applicant information is variable.

Section B
The plans available may change. They can be all those listed or one or more of them.

The Options available may change. They can be all those listed or one or more of them.

The Riders available may change. They can be all those listed or one or more of them.

The premium payment modes may change. Monthly Bank Draft could be changed.

Variability is limited to changing these portions only in context that remains compliant with Arkansas regulatory requirements. Any new benefit plans, benefit periods, or premium rates will be filed with the Arkansas Department of Insurance before use. The Company reserves the right to discontinue marketing benefit riders not mandated under state law.

Thomas Dunkin, President
United National Life Insurance Company of America
March 18, 2009